

# **PRIMARY CARE PROVIDER AGREEMENT AND SIGNATURE ADDENDUM FOR ENROLLMENT IN THE PASSPORT TO HEALTH PROGRAM AND TEAM CARE SUB-PROGRAM**

THE PROVIDER CERTIFIES THAT THE INFORMATION PROVIDED IN THIS ADDENDUM IS TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE DOCUMENT BEFORE SIGNING. IN CONSIDERATION OF CASE MANAGEMENT FEE PAYMENTS MADE FOR ELIGIBLE MEDICAID ENROLLEES, AND IN ACCORDANCE WITH ANY RESTRICTIONS NOTED HEREIN AND IN THE *PASSPORT TO HEALTH PROVIDER HANDBOOK*, THE PROVIDER AGREES TO THE FOLLOWING:

Enrollment in the Program under this Addendum shall be part of the Provider's Medicaid Provider Agreement for purposes of governing the Provider's participation in the Program. However, this Addendum shall not in any way reduce or modify the Provider's Medicaid Provider Agreement with respect to participation or provision of services under the Medicaid Program. The Provider hereby agrees to comply with all applicable laws, rules and written policies pertaining to the Montana Medicaid Program (Medicaid), including but not limited to Title XIX of the Social Security Act, the Code of Federal Regulations (CFR), Montana Codes Annotated (MCA), Administrative Rules of Montana (ARM) and written Department of Public Health and Human Services (Department) policies, including but not limited to policies contained in the Medicaid provider manuals and the terms of this document.

## **GENERAL OVERVIEW AND REFERENCES:**

A complete description of the Passport to Health and Team Care Sub-Program is contained in Administrative Rules of Montana (ARM 37.86.5101-5104, 37.86.5110-5112, 31.86.5120 and 37.86.5303) and the *Passport to Health Provider Handbook*. Passport to Health is Montana's Primary Care Case Management Program (PCCM) in which the 70% of Medicaid clients who are eligible must enroll. Each enrollee has a designated Passport provider also known as the Primary Care Provider (PCP) who is typically a physician, mid-level practitioner, or primary care clinic.

Team Care, a sub-program of Passport to Health, is a utilization control program for a much smaller number of clients who have demonstrated the need for additional case management measures and is designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a team consisting of a Passport PCP, one pharmacy, the Nurse First Advice Line and Montana Medicaid.

## **PROGRAM GOALS:**

Passport to Health is designed to build a strong relationship between the client and his or her primary care provider to achieve the following goals:

- Assure adequate access to primary care
- Foster a 'medical home' between the provider and client
- Improve the continuity of care

- Encourage preventive health care for children and adults
- Promote Early Periodic Screening Diagnosis and Treatment (EPSDT) services for children
- Reduce the inappropriate use of medical services
- Decrease non-emergent care in the Emergency Department (ED)
- Reduce and control health care costs

### **PROVIDER ENROLLMENT TYPE:**

A provider can enroll either as a “sole provider” or “group provider”. Pages three (3) and four (4) of this Addendum include a signature line for sole providers and lines for group providers and all PCP’s participating in the group.

A monthly case management fee of \$3.00 for Passport enrollees and \$6.00 for Team Care enrollees will be paid whether or not services are provided during that month.

### **CASELOAD MANAGEMENT:**

Page five (5) of this Addendum allows PCP’s to provide information that will help manage their caseload.

A monthly Passport enrollee list will be mailed to each passport provider by the first day of each month. A monthly Team Care enrollee list will accompany your Passport enrollee list if applicable.

A provider may disenroll a client for specific reasons detailed in Administrative Rule (see above ARM list) and in the Passport to Health Provider Handbook.

### **PASSPORT PROVIDER TERMINATION:**

The Department requires written notification at least 30 days prior to the termination date. Written notification must be sent to Passport Provider Relations Unit, P.O. Box 254, Helena, MT 59624.

**Complete and sign this Addendum, make a copy for your records and mail to:**

Passport to Health  
Provider Relations  
PO Box 254  
Helena, MT 59624

Phone number	(800) 362-8312
Fax number	(406) 442-2328

## Passport Provider Enrollment and Signature Information

### 1. Select Solo Passport Provider or Group Passport Provider Type:

\_\_\_\_\_ **Solo Passport Provider** - A Solo Passport provider will be enrolled in the Program as an individual provider with one Passport number. The Solo provider will be listed as the recipient's Passport provider. The Solo provider will be responsible for managing his or her individual Passport caseload. Case management fees will be paid to the individual provider under the Solo provider's Passport number, separate from fee-for-service reimbursement.

or

\_\_\_\_\_ **Group Passport Provider** – A Group Passport provider will be enrolled in the Program as having one or more Medicaid providers practicing under one Passport number. The Group name will be listed as the recipient's Passport provider. The participating providers will sign the Group signature page and be responsible for managing the caseload. Case management fees will be paid as a group under the group's Passport number, separate from the fee-for-service reimbursement. Please check one of the categories below that describes the kind of Group Passport practice:

\_\_\_\_\_ Private Group Clinic  
\_\_\_\_\_ Rural Health Clinic  
\_\_\_\_\_ Federally Qualified Health Center  
\_\_\_\_\_ Indian Health Service (IHS)

### 2. The Passport Provider's specialty is:

\_\_\_\_\_ Family practice  
\_\_\_\_\_ Internal medicine  
\_\_\_\_\_ Obstetrics/gynecology  
\_\_\_\_\_ Pediatrics  
\_\_\_\_\_ General Practice (Could include any above combination)  
\_\_\_\_\_ Other \_\_\_\_\_

### 3. Complete the following Passport provider enrollment information.

\_\_\_\_\_  
Passport Provider Name

\_\_\_\_\_  
Street Address, City, State, Zip Code

\_\_\_\_\_  
Mailing Address, City, State, Zip Code

\_\_\_\_\_  
Office Telephone Number

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
After Hours Phone Number

### 4. Solo Passport Provider and Group Passport Provider Signature(s)

\_\_\_\_\_  
Signature of Authorized Contact Representative for Provider

\_\_\_\_\_  
Date Signed

Each physician and mid-level practitioner employed by a clinic or a physician, who will be participating as a Passport PCP, must co-sign the Passport agreement, whereby the employee agrees to provide Passport patient management services under the terms and conditions of this agreement in its entirety. The clinic or physician understands and agrees that no employee may function as a Passport PCP if such employee is not a party to the Passport agreement.

## Passport Provider Caseload Management

Page 4 of 5

your practice. Information such as hours of operation and age restrictions will be provided to clients to allow them to choose a PCP who best meets their needs. You cannot limit/ restrict your caseload in a manner that results in discrimination of a protected class.

**Each PCP will be assigned a maximum of 1000 clients per provider.**

<b>Ages:</b>	_____	All ages	<b>Sex:</b>	_____	Female
	_____	Minimum age		_____	Male
	_____	Maximum age			

**The PCP’s regular business hours are:**

_____	to _____	Sunday
_____	to _____	Monday
_____	to _____	Tuesday
_____	to _____	Wednesday
_____	to _____	Thursday
_____	to _____	Friday
_____	to _____	Saturday

**Please list the clients who have been discharged from your practice. The Department will use this information to assure these clients will not be assigned to your caseload.** (attach additional pages if needed)

_____	_____
_____	_____
_____	_____
_____	_____

**List languages (other than English) that are spoken at your office.**

_____	_____
_____	_____